DOCUMENT RESUME

ED 159 557 CG 012 827

AUTHOR Green, Maurice R.
TITLE Treatment of Borderline Adolescents in Family Court Services.
PUB DATE 31 Mar 78
NOTE 26p.; Paper presented at the Annual Meeting of the American Orthopsychiatric Association (55th, San Francisco, California, March 27-31, 1978)

EDRS PRICE MF-$0.83 HC-$2.06 Plus Postage.
DESCRIPTORS *Adolescents; Behavior Problems; Clinical Diagnosis; *Emotionally Disturbed; *Family (Sociological Unit); Literature Reviews; Mental Illness; *Personality Problems; Program Descriptions; Psychopathology; *Psychotherapy
IDENTIFIERS *Borderline Personality; *Family Court Services

ABSTRACT

A recent revision of the proposed DSM III description of the borderline category is presented with reference to the work of Masterson and Grinker. The contributions of Roger Shapiro and his group to a psychoanalytic formulation of the developmental and familial dynamics are summarized with reference to genetic factors and the lack of validation, so far, for any general hypothesis. Treatment recommendations of Wolberg, Shapiro and Edith Jacobson are described. Grinker's operational criteria were chosen for the pilot study: a defect in affectional relationships with no enduring close ties; child-like angry relationships with parental or authority figures, particularly in the dysphoric group; low self-esteem, very poor sense of identity; a chronic depression characterized more by loneliness and boredom than by guilt or loss, and a pervading sense of anger or resentment. Cases are presented to illustrate treatment strategies. A brief differential diagnostic statement is made describing "borderline" as a separate category from other disorders manifesting oppositional, antisocial and violent behavior. (Author)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED159557

TREATMENT OF BORDERLINE ADOLESCENTS IN FAMILY COURT SERVICES

Read at the American Orthopsychiatric Association Meeting in San Francisco, California, March 31, 1978

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

M R Green

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND USERS OF THE ERIC SYSTEM."

Maurice R. Green, M.D.,P.C.
South Beach Family Court Services
777 Seaview Avenue
Staten Island, New York 10305

CG012827

Treatment of Borderline Adolescents in Family Court Services

*Maurice R. Green, M.D.,P.C.

Four years ago it was predicted that the diagnostic label Borderline Personality would become part of the official nomenclature (Green, 1974). Today it is listed in the latest revision of the projected D.S.M. III describing the typical borderline patient as a person characterized by marked unpredictable shifts of mood, inappropriate experiences of intense anger, chronic impulsivity and chronic depression, with profound identity disturbance of self-image, body image, gender identity and values in living. Such persons not only show a lack of coherent values but also an intolerance of separation from others, an intolerance for loneliness, and a profound sense of emptiness and boredom. Pathognomically they tend toward a schizotypal or histrionic personality. In a lesser degree this applies to the typical adolescent described 70 years ago by G. Stanley Hall (Green, 1965).

"The same youth with all his brazen effrontery may feel a distrust of self and a sinking of heart, which all his bravado is needed to hide. He doubts his own powers, is perilously anxious about his future, his self-love is wounded and humiliated in innumerable ways keenly

*South Beach Family Court Services
777 Seaview Avenue
Staten Island, New York 10305

felt, perhaps at heart resented, with a feeling of impotence to resist. The collapsing moods bring a sense of abasement and a complacency to all that comes, suggesting spiritlessness. Youth often feels itself lacking in some essential trait of manhood or womanhood... The world seems all the more hopeless because of the great demands which the opposite mood (more arrogant and demanding) has imposed."

The borderline adolescent has even more extreme fluctuations, more difficulty in sustaining significant relationships and shows more vulnerability to disappointments, rejections and separations.

However, in spite of the problems and limitations it must be kept in mind that the personality of the borderline sometimes adapts adequately to the conventional requirements of the environment, can maintain superficial interpersonal relations intact, and may suffer no regular impairment of habitual performances. However, he may suffer transient psychotic episodes, and frequently experiences symptoms of schizoid processes, withdrawal and depression. Giovacchini, Kernberg and Grinker describe a variety of subgroups within the category described above on a continuum of increasing severity of impairment. Masterson makes use of Grinker's four types explaining them as four

types of defenses emerging in faulty separation-attachment development. For example, Group I borderlines show no enduring relationships with anyone, acting negatively and angrily to all those encountered like the infants in Bowlby's stage of detachment and protest; Group II borderlines are inconsistent, ambivalent, moving towards and against persons of importance to them like Bowlby's abandoned infants in the stage of protest and wish for reunion; Group III borderlines don't exhibit any anger or other strong feelings simply imitating others and complying defensively like the Bowlby infants who have given up. Grinker's Group IV patients, who exhibit so much depression, represent the despairing position of Bowlby's infants who droop and cling with a depressive physiognomy.

Developmentally, adolescents suffering the Borderline Syndrome seem to come from parents one or both of which suffer Borderline Syndromes themselves who have particularly failed their child in the critical developmental periods of separation - individuation autonomy: about 9 months to 1½ years, 2 - 3 years and in the early adolescent or pre-adolescent period. The parents, one or both, struggling with their own lack of differentiation project their hostile defiance on to the child perceiving

his efforts at independence as ruthless, cruel and destructive sometimes with the overt fantasy that the parent will be killed through a heart attack or breakdown by the child's behavior. Sometimes a parent unable to accept their own passive immature dependent yearnings projects these on to the child experiencing the child then as voracious, demanding, parasitic, and insatiable. For example, in one family the daughter was seen as "spoiled" and insatiable, the son was seen as hostile and irresponsible and the family fantasy that supported the atmosphere of crisis was that the father would have a nervous breakdown and commit suicide or die suddenly of a heart attack. Even though the father was in excellent health and had no signs of a serious depression he, himself, entertained these fantasies constantly. He frequently stormed off complaining that he couldn't stand it anymore, without ever making clear what "it" was that he couldn't stand. Such "crisis" style of stormy behavior frightens and provokes the adolescent interfering with the development of increased competence and responsibility, key requirements for independence. However, there is no solid evidence that the parents are at fault in most of these cases. Genetic factors may also play an important part.

The family's developmental task here is to facilitate the adolescent person's sense of autonomy, capacity and skills for more independent activity within his particular socio-economic milieu. The family should also enhance his self-esteemed gender identity of manhood or womanhood as defined by the values he believes. Thus with the help of the parents, peers and the social institutions of our society the adolescent will overcome early symbiotic ties and inappropriate defiance to assert himself with some dignity and autonomy as a budding adult. The family particularly must avoid retaliation or withdrawal from the repeated experimental behavior of the adolescent providing firm limits with flexibility. This is particularly difficult with youngsters who are hypersensitive and over-react due to constitutional factors.

In the borderline family, the pattern is often characterized by retaliations and withdrawals threatening the young adolescent with threats of rejection and loss, and thereby interfering with gradual and realistic development of independence. Such youngsters conceptualize the family drama in sadomasochistic terms, and are preoccupied with sadomasochistic erotic fantasies during and in between episodes of masturbation. These youngsters also develop a mild chronic depression that tends to be very persistent, though sometimes difficult to detect behind the defensive restlessness, substance abuse and

pseudo-arrogant histrionics they tend to indulge in.

However, it must be stated that the evidence for a family pattern, that characterizes the borderline youngsters described above, is very sparse indeed. Many so-called borderline adolescents come from families containing a fair number of schizophrenics, depressions, bi-polar cases, etc. and may be said to be at risk, probably, for a similar illness. Parents vary from being severely ill to being very well integrated, empathetic and insightful.

Wolberg (1973), summarizing the literature, insists on the long term aspect of the treatment process of these patients, often requiring short periods of hospitalization and psychotropic medication. They are often made worse by phenothiazines but respond to relatively small doses of tricyclic drugs. Masterson and his co-workers believe that such long term treatment may be shortened by very active forceful confrontational techniques. They advocate this, especially at the beginning of treatment, with firm guidelines and unambiguous judgements of actions and decisions. Other studies have shown how loosely structured environments impede progress while a more authoritarian social structure facilitates maturational growth of borderline personalities.

Masterson finds that the initial period of aggressively working through the difficulties of the therapeutic alliance leads to an opening up of the underlying depression. Once the depression is engaged and the therapeutic alliance is strengthened, the neediness of the depressed youngster becomes more overt. He then needs to separate his morbid guilt from a healthy sense of accountability, and work through the painful memories of loss and injured self-esteem in the current life situation. At this stage of treatment Masterson and his co-workers agree with others that a warm empathic nurturant relationship becomes important. However, if this is offered prematurely it invites the contempt of the adolescent who sees the therapist as just one more hypocritical, placating adult fool.

Roger Shapiro (1976) and his co-workers at N.I.M.H. (personal communication) have described the conjoint treatment of borderline adolescents and their families. They emphasize the on-going interactions between these youngsters and their parents in which the borderline splitting of ego states and the maintenance of symbiotic ties could be directly observed in the family session. The attitudes and words of the parents that supported the pathology of the adolescent were recorded and reported at staff conferences. The parents were then confronted directly with these reports in family therapy sessions.

The borderline adolescent was seen three times a week for intensive individual psychoanalytic psychotherapy; he participated in conjoint family therapy sessions once a week. The mother and father were seen separately once a week for conjoint marital therapy. Shapiro and his group showed how unconscious assumptions shared by the parents and children repeated similar conflicts from the parents' own family of origin. These unconscious family assumptions intensified the negative (bad-me) quality of the borderline adolescent's experience, and interfered with the integration of acceptable aggressive and dependent tendencies into a healthy self (good-me). One can see how this works most glaringly in the mother-infant interaction wherein the mother is unable to provide the "holding environment" (Winnicott, 1955, 1969), without rejection or vindictiveness toward the infant's demands. By her own hostile vindictive behavior, the mother validates his "bad-me", and makes it increasingly difficult for her child to integrate his dependent and angry feelings into the increasingly fragile relationship he now has with her.

All parents seek partners who will complement and reinforce certain unconscious expectations and wishes. Each child is responded to partly in terms of his realistic

attributes and problems, and partly in terms of his participation in the parental fantasies which have developed from unresolved problems the parents had as children with their own parents. This is particularly true for the borderline adolescent who obtains egocentric grandiose self-deluding experiences of power and status through the parents ambivalent "acting out" with him/her.

Edith Jacobson said (p. 285, 1976) of the treatment of borderline patients, "These patients show ego distortions and superego defects, disturbances in their object relations, and a pathology of affects beyond what we find in ordinary neurotics. For this reason they usually need many years of analysis with slow, patient, consistent work in the area of ego and superego functioning, with great attention to their particular methods of defense and to the affective responses...This work is so difficult because such patients call into play auxiliary defense and restitution mechanisms which impair their reality testing to a greater or lesser extent...."

At our Family Court Clinical Services we have neither the funding nor framework of N.I.M.H. to provide the 6 - 8 hours per week of a highly trained team of psychiatrists, nor do we have the time and personnel for the lengthy psychoanalytic treatment recommended by Dr. Jacobson, However,

as there was only one psychiatrist in the clinical services, he joined forces with a very experienced social worker who had worked for the Family Court for many years, in attempting to apply the insights of Shapiro and Zinner in a somewhat modified version. The borderline adolescents were chosen from among those referred to us by the Court on the basis of the families' willingness to collaborate, an earlier history of some successful achievement in school and athletic activities, and the genuine interest both co-therapists felt in these particular adolescents. Incidentally, in looking over our own data, we found that without exception in every single case whether male or female each borderline adolescent was either currently having, or had had an intense symbiotic relationship with one of the parents that included the parent's own regressive child-like behavior as well as infantilizing behavior toward the adolescent. The extent to which the adolescent, himself, causes this behavior in the parent is difficult to judge.

We shall present two case vignettes to illustrate our experience, the course of treatment and the follow-up. Diagnostic criteria sets have been described by Masterson, Gundersen, Kernberg and Grinker. Grinker's set, derived

from statistical cluster, discriminate and factor analysis, show the following general characteristics: a defect in affectional relationships, chronic angry explosions and lack of consistent self-identity. This set also includes chronic depression, associated with loneliness rather than with guilt or shame. We used Grinker's criteria which seem more operational for our context. Both cases showed the defect in affectional relationships: they had no close relationship to anyone; were involved in a child-like angry demanding relationship with a parent in the first case; a big sister in the second. The parent figures were engaged in a mutually ambivalent relationship over a period of many years characterized by outbursts of excessive anger and child-like demands. Both adolescents showed low self-esteem and poor sense of identity - the girl felt unattractive and the boy felt unmanly. Each one felt bored and lonely but had difficulty formulating what they wanted or what career line interested them.

Our first case, Mary Farwell, was an unmarried 19 year old mother of English and Scottish extraction, the youngest and only girl in a family with three brothers. She was referred to the Court Services with a lengthy, seven year Court history of running away, promiscuity, amphetamine,

barbiturate and hallucinogen abuse; and she was under investigation for charges of neglect and abuse of her 2½ year old son. The father of the borderline patient, a merchant seaman, recalls nothing of his early childhood except that he was sent to an orphan asylum at an early age. He never had any further contact or knowledge of his parents. The orphanage, run by a very strict Church, provided a consistent well structured severe and austere way of life. It was run by distant, righteous and punitive authorities who punished frequently with whips, belts and sticks. In his teen years he was sent to work on a farm and he ran away, lied about his age and went to sea. The mother, a jolly plump red-cheeked short woman, grew up in a harbor town with a father who was killed in an accident when she was eight years old, and a mother who was chronically ill. She helped her mother raise her six little brothers and sisters. It was clear that neither of these parents could accept their own dependency needs for which there was sparse nourishment. Likewise, there was little room for autonomy until their adult years. Nonetheless, they presented a strong sense of devotion, responsibility and genuine collaboration in the treatment program which was conjoint family sessions for 1½ hours with the co-therapists every week, and availability for

telephone calls in between.

The daughter, Mary, like most borderline patients in the first interview, was hostile, touchy, accusatory, contemptuous of the clinic, the Court, the Judge, the Bureau of Child Welfare, her parents (who were supplementing her welfare checks with generous contributions of food, clothing, furniture and money) and the co-therapists. She was living with a mildly retarded Greek musician after rejecting the three other men, all black, with whom she had lived since her baby was born. She deftly manipulated crises between her lovers and her father while she righteously placed herself as the innocent victim of her father's alleged racism or the innocent victim of her lover's alleged brutality. However, as time went on, the stormy sessions subsided, the father emerged as a stronger figure who became friendly with her lovers. She was exposed as prevaricating, and provoking both men. This was done without any vindictiveness expressed toward her by either one. Gradually she got in touch with her early feelings of her mother's preference for her brothers and her jealousy of them. We also explored the mutually seductive infantilizing experiences she had with her father, wherein he would baby her when she visited his home and wait on her hand and foot. Sometimes she would sit in his lap and they would talk baby talk to each other. In the course of treatment she renewed her alliance with her mother and

dropped her negative identification with her "bad boy" brothers. She started, at 19, to spend more time with her mother and her child, learning domestic skills of cooking, sewing, shopping more thriftily, keeping house, and so on. Eventually, she gave legal custody of the child to her mother and went off to school, after getting her high school equivalency diploma. Her Greek musician lover developed insight into how she was using him, in his own rescue fantasy, against her father. He became impatient with her childish exploitative demands, developed sympathy towards her parents and left her to go to school in another city for more serious musical training. The crucial turning point in therapy was to penetrate the ambivalent symbiotic relationship between herself and her father. Then she could be released from the defiant hostile binding interaction she had sustained with him. This would help renew her development of her own considerable intelligence and skills rather than be stuck in an infantilized exploitative position.

The second case, Tony Zuso, the son of a prominent lawyer and politician, was referred to the Court for a three year history of escalating truancy, amphetamine, diazepam and hallucinogen abuse, breaking into a neighbor's house, stealing and selling stolen goods, and disruptive

behavior at school. He had an older sister and brother who led conventional successful careers in school and work.

The father was born in northern New England the eldest in a family of five. His father, the maternal grandfather, suffered manic-depressive episodes with alcoholism, and at times earned large sums of money while at other times he was in great debt. The father went to work at an early age, was brilliant academically, earned scholarships and graduated from a prestigious law school.

The mother was the youngest in a family of eight, from a small Appalachian mountain village in Virginia. Her parents were poor, proud, rural subsistence farmers with considerable skills in music, weaving, art, crafts and carpentry. She was her father's favorite and earned a scholarship to college where she met her husband. She gave up her career plans to work full time to help him through law school.

Both parents were very ambitious, and as he became wealthy and prominent, she took care of entertaining on an elegant scale. She managed their social calendar to help his career, managed the household, the children, the activities at the yacht club and the country club.

When the patient was a year old, the mother discovered the father's infidelity and had a brief depressive episode. When the patient was 2½ years old, the father discovered the mother's infidelity, and had a prolonged seige of jealous rage and hostile vindictive behavior. This gradually subsided as they both restrained themselves to avoid scandal at a vulnerable point in the father's political career. After this, the oldest son joined the merchant marines and went off to sea, the daughter became closely allied with the father against the mother, and the mother developed a very protective symbiotic relationship with her son keeping him with her everywhere she went. She more or less excluded him from involvement with the father.

The boy seemed to thrive as the mother's companion and favorite. He did brilliantly in school, was well-coordinated and skillful in athletics and was a great help to her on board her racing sailboat at the yacht club. He was rather aloof with his peers but presented no conduct difficulties for his private school during these years. When he was 10 years old, the mother suffered a severe attack of equine encephalitis that led to a prolonged hospitalization and permanent brain damage. The father

became very depressed: at the surface, with guilt, blaming himself for his past misbehavior; but unconsciously angry at her for abandoning him as the very capable manager of his household, children and community relations. He gave up his political career, lost most of his money through hospital and medical bills as well as some very unwise decisions. At the same time, he devoted himself to looking after his children in a very anxious, guilty, overprotective and controlling way. His son became depressed and declined in his academic work at school. The daughter spent 2-3 years taking the mother's place and doing all the managing, cooking, supervising and nurturing of the father and son. They remained estranged from each other, throughout the entire time. She graduated high school and went away to Nebraska, enrolling in an agricultural school to begin a career as a farmer. When she left, Tony became involved with a delinquent group of boys, was expelled from his private school for drug abuse, and began truanting with increasing frequency at the public school. The mother by this time was stabilized at a mildly retarded level able to cook, clean house and shop with lists prepared by the father. However, she was unable to handle anything more complicated. She contented herself with watching television and listening

to music when she wasn't working. In the meanwhile, about six months after the daughter went away, the father had a mild stroke. He completely recovered from this, but it contributed to the chronic crisis atmosphere with which the family entered our treatment program.

Tony, the father, the mother and the daughter (who had been summoned from Nebraska for the initial two meetings) met conjointly with the psychiatrist and co-therapist for 1½ hour conjoint family sessions (two the first week and once weekly thereafter). The brother was also called home briefly from his duty to join one of the conjoint sessions. The mother was excused after the first meeting because of the unusual stress it placed on her limited resources. Later, the daughter returned to Nebraska. Just before the end of her term there, she was raped on the campus by a local non-student youth, and returned home to recuperate. The father had a mild heart attack following this. However, he made a good recovery; but he had to limit his workload and prepare for early retirement. Fortunately, he had a position with a very large corporation that ensured a good pension and continued benefits.

The psychiatrist saw the son regularly, the father at intervals of about once a month, and the sister occasionally,

for help in clarifying problems and issues that arose. She renewed her relationship with a former boyfriend, and a year after Tony entered therapy, she became engaged. Tony remained estranged from his father throughout the treatment program but became very friendly with his sister's boyfriend. He was given 100 mg. imipramine which the father made sure that he took. As the signs and symptoms of his depression lifted, his academic work improved and he achieved the Dean's Honors list. His truancy stopped completely. His delinquent friends by this time had disappeared from the picture - (one had moved away, one had been sent to prison and the third was sent to a group home). He continued to be sullen, defiant and resentful at home towards his father who responded with feelings of helpless rage and vindictive outbursts. However, after his heart attack the father became more emotionally detached and withdrawn from his son, but at times trying to be friendly. He began working with him on projects of various sorts and tried to maintain a calm, firm demeanor. The boy seemed to respond to this with respect and better behavior but no real warmth. He, at best, achieved a polite reserved friendly relationship with him at the time treatment was terminated. Shortly after the sister's engagement and the

announcement of her plans to move to rural Pennsylvania, it was decided that the son had too little resources here. He left our program to live with a family near his father's hometown in New England. He had spent many summer vacations with this family and they were very fond of him even though he showed little feeling for them. He settled into the small town life, attended school regularly, became very friendly with boys and girls his own age who admired his superior competence in sports, hunting, fishing, auto repair and electronics. After one year of this life, he was discharged from our program.

Both of the borderline adolescents described above were continued on probation supervision throughout the entire treatment program. We found this very useful in two ways. First of all it helped fit into their splitting - the probation and the Court were the Bad Others, and the clinical services were the Good Ones. Secondly, it provided superego reinforcement against the tendencies of these families to escape from treatment and avoid engagement as the confrontation phase moved along. These youngsters were no exception to the prevailing tendency of borderline personalities to experience anger and contempt for their therapists with underlying expectations of vindictive and

humiliating retaliation.

Our treatment strategies included five points that are of particular importance in work with this group:

First of all, therapists must be very active in initiating and maintaining therapeutic movement.

Secondly, they must carefully walk the tightrope of maintaining a simple direct human unique person-to-person relationship and avoid acting out counter transference feelings of vindictive anger or of overprotective infantilizing nurturance.

Third, they must pay especial importance to feelings and behavior apart from the verbal content of sessions.

Fourth, they must avoid premature interpretation, intellectualization or any tendencies to encourage regression ("therapeutically" or otherwise).

Fifthly, the emotional engagement of responsible participation in the therapeutic alliance is more important than providing insight through interpretation. However, properly timed insights, in the framework of such engagement, are invaluable in discouraging regressive tendencies.

In our work we explored the family history directly and conjointly with all the family members. As time went on

we confronted the parents with their tendency to disallow inappropriate dependency strivings and autonomy needs. We showed them specific examples from their own experience. In this way we sought to interrupt the symbiotic relationship. We confronted the adolescent with their tendency to split into all-good and all-bad selves and others- helping them accept their own vindictive rage, see how they project it on to their parents and provoke their parents. At the same time, we tried to enhance their own sense of responsible independence by focusing on their real assets and skills.

Unfortunately time does not permit the presentation of illustrative detail that would show the process step-by-step. Nor does the above comprise all varieties of borderline adolescents. However, it does represent a large category of fairly bright resourceful borderline adolescents, confirming previous studies of this group and their use of massive denial, projection and projective identification. They also show impulsivity, confused sense of self and facile identifications with others, as well as a mild chronic depression.

There is another distinct group of borderline adolescents with specific learning disabilities that will be described in another paper.

Because of the Family Court framework in which we function, most of the borderline adolescents we see are also in the diagnostic categories (DSM II - group delinquent, runaway, drug abuse, unsocialized, aggressive, etc.) of DSM III conduct disorders. Such violent, antisocial and oppositional behavior disorders, as a general category, comprise the entire range of other psychodiagnostic categories including organic mental disorders, mental retardation, intermittent explosive disorders, undersocialized conduct disorder, socialized conduct disorder, psychotic disorders, oppositional disorders and adjustment disorders. We cannot at this time give the percentage of juveniles that pass through this Family Court in one year that would qualify for the category of Borderline personality disorder (DSM III - 301.83) but our impression is that it makes up a considerable size.

We have presented a brief review of the diagnostic concept, described research found useful to our treatment program, presented two illustrative cases and described general treatment strategies that we believe would be useful to clinicians in Mental Health Services to Family Courts elsewhere.

I wish to thank Dr, Michael Stone of Cornell University Medical Center for his helpful criticism.

BIBLIOGRAPHY

Green, Maurice R. (1965) Depression in Adolescence, Contemporary Psychology 2(1965):42-47

Green, Maurice R. (1974) a review of The Borderline Patient, Wolberg Arlene; In: Journal of the American Academy of Psychoanalysis, 2(1):85-87; 1974 by John Wiley & Son, Inc.

Jacobson, Edith (1971) Depression; comparative studies of normal, neurotic and psychotic conditions International U. Press: N.Y. 1971

Kernberg, Otto (1975) Borderline Conditions and Pathological Narcissism, Jason Aronson, Inc., New York

Masterson, James (1972) Treatment of the Borderline Adolescent, a developmental approach. Wiley-Interscience: N.Y. 1972

Shapiro, Edward R.; Zinner, John; Shapiro, Roger L.; Berkowitz, David A. Family Contributions to Borderline Personality Development. (Personal Communication)

Winnicott, D. W. (1955) "Clinical Varieties of Transference" in Collected Papers: Through pediatrics to psychoanalysis, Basic Books: N.Y., 1958.

Winnicott, D.W. (1969) "Use of an Object" International Journal of Psa. 50.

Wolberg, Arlene (1974) The Borderline Patient, International Med. Bk. Corp.: N.Y.